



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CHRISTINE L. TRUITT, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-3403-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

AUGUST 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since a detailed history was done, a general and neurologic exam was performed, and extensive counseling was done with the patient and his wife regarding his post-concussion symptoms of headaches, cognitive problems, memory problems and anxiety, and medication reviewed all of which had to be done through translation and care taken that the patient comprehended everything clearly, we feel this visit does meet the criteria of 99214 and this claim should be paid."

Amount in Dispute: \$160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed E/M code 99214 for the date above. Texas Mutual declined to issue payment because the documentation did not meet any of the required components – detailed history, detailed examination, and moderate complexity decision-making. The requestor's history is incomplete and absent the Review of Systems and Past, Family, Social history. No physical examination was documented. Thus, two of the three components have not been met. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2013	CPT Code 99214 Office Visit	\$160.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-150-Payer deems the information submitted does not support this level of service.

- 890-Denied per AMA CPT code description for level of service and/or nature of presenting problems.
- CAC-193-Original payment decision maintained. Upon review it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

Does the documentation support billing of CPT code 99214? Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the office visit, CPT code 99214 based upon reason codes "CAC-150" and "890."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

A review of the submitted medical reports finds that the requestor did not document at least 2 of the 3 key components to support billing CPT code 99214 on the disputed date of service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		03/25/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.